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Introduction

Health professionals in primary care may be the first to notice or hear of patients who are experiencing obsessive compulsive disorder. While care from specific professionals is likely to be needed, Andy Young explains how practice nurses can direct the care for these patients

Abstract

Obsessive compulsive disorder (OCD) is a mental health condition in which the quality of the sufferer's life is adversely affected by intrusive or inappropriate thoughts and actions. People with OCD have repetitive thoughts that cause anxiety symptoms. In order to control these thoughts and their associated unpleasant effects, the person develops behaviours they feel might prevent the thought from becoming reality. OCD is found in 1% of the UK population, affecting men and women equally.

There is evidence to suggest that OCD runs in families and has some genetic basis, and it appears to be partly caused by alterations to the balance of serotonin and/or dopamine in the brain. OCD often develops in childhood or young adulthood, and the presence of obsessive and compulsive phenomena may require referral and treatment from Child and Adolescent Mental Health Services. 'Pathological doubting' and the inability to distinguish between the memory of real or imagined actions is a central feature of OCD, especially compulsions associated with the disorder. The primary care team have an opportunity to recognise OCD symptoms and intervene before the condition worsens and the patient requires hospitalisation.

Key words: Obsessive compulsive disorder, Mental health, Behavioural therapy, Case study

Anxiety is a common mental health condition that is mainly treated in primary care, and obsessive compulsive disorder (OCD) is a specific type of anxiety disorder. The term OCD can sometimes be mistakenly used to describe people who are both fastidious and meticulous in their actions, particularly with regards to activities such as cleaning; however, the anxious thoughts of true pathological OCD can lead to widely differing behaviours. People living with OCD experience repetitive thoughts that cause anxiety symptoms. In order to control these thoughts and their associated unpleasant effects, the person develops behaviours they feel might prevent the thought from becoming reality. Some resemble 'normal' behaviours, such as ensuring that they have locked a door or rechecking that they have switched off a light or the oven.

While everyone experiences occasional, unconscious, intrusive thoughts, what differentiates these from the distressing, obsessive thoughts experienced in OCD is the meaning attached to them by sufferers. For those with OCD, having a thought about an action is akin to performing it (Barlow, 2014). A person with OCD is generally aware that there is no logical basis for their feelings and actions but cannot control them, nor can they control the anxiety

generated as a result. For someone with OCD, these actions only provides temporary relief before the thoughts return and they have to repeat the behaviour, and in this way the behaviours become compulsive. For those with OCD, the familiar anxious or intrusive thought is far more intense and the behaviour markedly 'abnormal'. Furthermore, individuals with OCD tend to have an inflated sense of their own responsibility for preventing harm (Salkovskis, 2017).

This article focuses on the clinical assessment and treatment of obsessional patients in primary care, and uses a case study to explore the unique role of the practice nurse in promoting mental wellbeing and minimising risk to the patient. The author seeks to define OCD and explore common misconceptions of the disorder, explaining the difference between obsessions and compulsions, and describing the nature of intrusive thoughts, images, impulses, and urges.

Table 1: Types of Obsessive Compulsive Disorder

National Institute for Health and Care Excellence, 2006

<i>Key features of OCD</i>	<i>Commonly associated fears</i>
Checking e.g. taps or doors	Flooding or burglary
Cleaning and contamination	Germs of dirt that could cause harm
Hoarding	Losing happy memories or wastefulness
Repetitive thinking	Humiliation or danger
Avoidance of objects or situations	They will harm themselves or others
Orderliness	Harm or disaster will occur
Impulses to perform obscene acts	Embarrassment or ridicule

Obsessional thinking and compulsive behaviour

The most common obsessions are about contamination or involve pathological doubt. Occasionally the ruminations may be in the form of impulses or vivid images, rather than thoughts, usually with some disturbing content such as violent acts or socially unacceptable sexual practice. Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. They are often carried out in order to avoid or neutralise the feared consequence of an obsession. Rituals of checking and cleaning are most common but compulsions for symmetry, hoarding and counting are also evident where they relieve tension by preventing obsessions. For example, a patient may worry about things not being 'right' or something bad happening. In OCD, disturbing and distressing thoughts are nevertheless recognised as 'own thoughts' (i.e. they are unwanted, but not hallucinatory) and they are recognised by the patient as being irrational (i.e. not delusional). Psychosis can present in a similar manner to OCD, with extremely intense thoughts but unlike delusional beliefs, there is room for doubt. Therefore, people experiencing OCD symptoms can be said to have insight into their condition and frequently acknowledge that they have a psychiatric problem and require help.

First-line treatment for OCD

The management pathway of choice in OCD is cognitive behaviour therapy (CBT). This involves behaviour strategies such as exposure to the trigger (e.g. repeatedly checking doors and locks before leaving the house) and response prevention (e.g. preventing or limiting checking). This is supported by a challenge to attributions, using 'Socratic questioning' and an exploration of beliefs, aided by relaxation techniques. The Socratic method is a form of dialogue that presumes that the person already knows the truth, but requires help in order to recognise it. Alternatively, the 'flooding' technique involves subjecting the patient to intense exposure of the anxiety-provoking stimuli until the severity of the fearful emotion subsides. This is not so commonly used in modern practice. Serotonin reuptake inhibitors, such as clomipramine and fluoxetine, have also been found useful for OCD in conjunction with CBT or behaviour therapy. Providing reassurance and support to patient and carers is important (Van Niekerk and Purdon, 2018).

What do patients need to know about cognitive behaviour therapy?

CBT can be carried out individually or in a group of people. It can also be provided through self-help books or computer programmes (Hamdeh et al, 2018), but it can be time consuming and requires motivation and commitment from the patient. Treatment usually involves 5–20 sessions weekly or fortnightly and sessions vary between 30–60 minutes. Problems are broken down into separate parts and it is usual to keep a diary to help identify individual patterns of thoughts, emotions, bodily feelings and actions. During therapy, the relationship between these components is explored and techniques are devised to help change unhelpful thoughts and behaviours.

There is usually some homework or experiments between sessions and this may include keeping diaries. As an example, 'response prevention' is practised where compulsions are not carried out with discussion of thoughts, feelings, actions and outcomes. Therapy appointments are used to do cognitive work, carry out and plan experiments, and review how the tasks were undertaken and how further success can be built (Van Niekerk and Purdon, 2018). In many parts of the UK, people can access proven talking therapies, such as CBT with exposure and response prevention, through an NHS scheme called Improving Access to Psychological Therapies (IAPT). Other evidence-based approaches include the use of OCD-NET, an online programme designed to treat OCD.

Box 1: Screening questions for obsessive compulsive disorder

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there any thought that keeps bothering you that you'd like to get rid of but can't?
- Do your daily activities take a long time to finish?
- Are you concerned about putting things in a special order or are you upset by mess?
- Do these problems trouble you?

National Institute for Health and Care Excellence, 2006

Case Study

Polly, a 20-year-old design student, presents at her local GP surgery for a routine eczema review. In consultation with Alice, a general practice nurse, she reveals a 7-month history of anxiety with increasing repetitive behavioural routines, and says that she is now finding it difficult to leave her shared house without undertaking lengthy repetitive checking of locks, taps, and switches. She worries that she is taking longer and longer, so much so, that she is often late for work. Polly also tells Alice that she is struggling to progress at university and has missed some important assessment deadlines because of her mental health.

Lately, Polly has become obsessed with details, particularly in relation in her coursework, and has a fear of handing in drawings that are too sexually explicit. She is also worried about losing her part-time job in an independent bookshop, as recently some of her colleagues have been made redundant. Polly had a similar episode when she was 18 years old around the time of her A-Level examinations, but that settled within a few weeks which is why she has delayed seeking help. She wants to know what is wrong with her and what treatment options there are that do not require medication. Alice speaks to Polly's GP to discuss the case.

How can a primary care team help Polly?

Regarding the case study, Polly will need to consider how her obsessive thoughts lead to certain other thoughts, sensations, feelings and actions. CBT recognises how these aspects interact in reinforcing cycles. This can potentially help Polly change how she responds to her thoughts and feelings, leading to alternative outcomes and a reduction in distress. In the first instance, some cognitive behavioural treatment would be appropriate with follow-up. If this is ineffective then a serotonin reuptake inhibitor drug should be considered.

The practice nurse (Alice) might usefully encourage Polly to seek help from her university and consider her study options. It might be possible for her to access additional support or counselling, or even step-off the course temporarily until she feels better and more able to cope with academic life.

Medication is not recommended as a sole treatment method for OCD, but is often used as an adjuvant treatment if the patient is willing. It may work by reducing the severity of the obsessive compulsive symptoms or by 'taking the edge off' some of the anxiety precipitated

by OCD, but CBT should always be the principal method of treatment. CBT helps patients change how they think (cognitive) and what they do (behaviour). CBT focuses on 'here and now' problems and difficulties, and does not seek to look at the past for causes for current behaviour and feelings, and this distinguishes it from some other forms of talking therapy such as psychodynamic therapy – also known as psychoanalysis.

OCD has been described as 'highly disabling, heterogeneous and complex' and research suggests that there is still a gap between theoretical knowledge of treatment and ensuring that relevant treatments are available when patients need them (McKay, 2018). While OCD is a treatable mental health condition, clinicians should not ignore the need for risk management. Having an anxiety disorder is an independent risk factor for suicide. Therefore, in patients with an anxiety disorder such as OCD, the primary care team should also assess for suicide risk (Sareen et al, 2005).

The following questions will be helpful in assessing patients:

- Are you becoming desperate?
- Is it all too much for you to manage?
- Do you ever have thoughts that you would be better off dead than living as you are now?
- Do you have thoughts of death or suicide?
- Do you have a specific plan?
- What would stop you killing yourself?

Alongside risk factors, it is necessary to consider protective factors such as adequate social support (Kutcher and Chehil, 2007). Consequently, if a practice nurse does not feel confident to undertake a risk assessment, they should refer the patient to a colleague who can as soon as possible.

CBT can be accessed in primary care through IAPT, but it can be difficult to implement if someone is acutely distressed as it requires a level of clear thinking, and depression is often a comorbid problem. Depression may present as a comorbidity, particularly if someone has lived with OCD symptoms for a significant period of time. When depression accompanies OCD it appears to affect treatment outcomes negatively. (Salkovskis, 2017). In regard to this type of case, the primary care team should consider making a referral to mental health services. NICE (2006) propose a stepped-care approach to treating OCD (ie graduated, proportionate treatment based on symptoms). To optimise delivery of care the primary care team must work collaboratively and strive to promote recovery, by emphasising self-management, by focusing on what patients can do rather than what they can't, and by looking at social and not simply medical outcomes. At the core of recovery orientated practice, must be the fostering of hope.

Conclusion

In many cases, OCD can be successfully treated, in primary care with serotonin reuptake inhibitors (SSRIs) given at a higher dose than that used for depression. However, drug treatment may take longer to achieve and symptoms may return on cessation of the

medication. And of course, pharmacological treatment is only part of the treatment for OCD. Patients will also need psychological support from the primary care team and the use of positive examples to enable them to develop functional ways of interacting. Behavioural and/or group therapy and other cognitive interventions form equally important strategies, for helping those with OCD to cope with such a debilitating condition. A person-centred approach to care and treatment, requires the primary care team to try to understand patients' perspectives, what matters to them, and how their views have been formed and the practice nurse has a pivotal role in ensuring that this happens.

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Box 2: Key Points

- Obsessions occur when one's own thoughts are repetitive, intrusive and unpleasant
- Compulsions are used to neutralise or prevent obsessions
- In obsessive compulsive disorder (OCD) resistance to intrusive thoughts or images diminishes with chronicity
- Exposure and response prevention are key treatment strategies
- Cognitive behavioural therapy (CBT) is the treatment of choice in OCD
- CBT is a time-consuming therapy that requires work and commitment from the patient outside of the therapy sessions.
- For clients who are under the age of 18, the presence of obsessive or compulsive phenomena may require child mental health service's involvement

Box 3: CPD reflective practice

- How would you investigate and manage the patient in general practice?
- What are the treatment options?
- What are the key points about CBT you would need to make sure the patient is aware of?